X 2015-1936

Washington State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504008	A. BUILDING ______ B. WING ______	12/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES COUNSELING CENTER	1175 CARONDELET DRIVE RICHLAND, WA 99352

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L 000	INITIAL COMMENTS STATE LICENSING SURVEY A state hospital licensing survey was conducted at Lourdes Counseling Center on 12/8/2015 - 12/11/2015 by Lisa Sassi, RN, MN; and Alex Giel, EHS. The Washington Fire Protection Bureau conducted the fire life safety inspection during that time period. ASE #CZZR11 RECEIVED JAN 26 2016 DEPARTMENT OF HEALTH Office of Investigation and Inspection	L 000	1. A written Plan of Correction is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHEN the correction will be completed; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance, including relevant benchmarks for success, when monitoring is part of the plan. 3. Your Plan of Correction must be returned within 10 business days from the date you receive the hard copy of Statement of Deficiencies. Your Plan of Correction is due to be mailed on January 20, 2016 or sooner. 4. Return the original report with the required signatures.	
L 380	322-035.1P POLICIES-EQUIP MAINTENANCE WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures	L 380	See attached POC	

By signing, I understand these findings and agree to correct as noted:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barbara Mead	VP Behavioral Health	1/19/16

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L 380	Continued From Page 1 consistent with this chapter and services provided: (p) Cleaning, inspecting, repairing and calibrating electrical, biomedical and therapeutic equipment, and documenting actions; This WAC is not met as evidenced by: Based on observation and interview the facility failed to develop and implement specific policies and procedures to address patient home equipment receiving inital checks before entering into facility. Findings: On 12/10/2015 at 9:00 AM Surveyor #2 observed two patient rooms with medical equipment. Room D had a home oxygen machine plugged into the wall and Room Q had a home CPAP (Continuous Positive Airway Pressure) machine stored on top of the desk in the patient room. Both items did not receive inital checks prior to using equipment in the facility. The infection control nurse (Staff Member #1) was unware that the facility was allowing home equipment for use into the facility.	L 380		
L 420	322-040.1 ADMIN-ADOPT POLICIES WAC 246-322-040 Governing Body and Administration. The governing body shall: (1) Adopt written policies concerning the purposes, operation and maintenance of the hospital, and the safety, care and treatment of patients; This WAC is not met as evidenced by: Based on document review and interview, the facility failed to demonstrate that the governing body addressed issues related to purposes,	L 420		

DAM

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L 420	Continued From Page 2 operation and maintenance of the psychiatric hospital and its patients. Findings: 1. In review of the facility documents titled, "AMENDED AND RESTATED BYLAWS OF OUR LADY OF LOURDES HOSPITAL AT PASCO" and "Lourdes Health Network Board of Directors Minutes" from three meetings in 2015 (January 27th, April 28, and September 22), it was noted that issues related to Lourdes Counseling Center (psychiatric hospital) were not addressed. 2. On 12/10/2015 at 9:30 AM Surveyor #1 interviewed the Chief Nursing Officer (Staff Member #8) about governing body oversight for Lourdes Counseling Center (psychiatric hospital). S/he could not identify whether issues related to the psychiatric hospital were addressed by a governing body.	L 420		
L 590	322-050.7A INSERVICE ED-UPDATE (7) Make available an ongoing, documented, in-service education program, including but not limited to: (a) For each staff person, training to maintain and update competencies needed to perform assigned duties and responsibilities; This WAC is not met as evidenced by: Based on observation and interview, the facility failed to assure annual staff competencies were updated. Findings: 1. a. On 12/10/2015 at 9:45 AM Surveyor #1	L 590		

BAM

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L 590	Continued From Page 3 interviewed security guards (Staff Members #6 and #7). Both persons were responsible for a variety of security activities, including direct patient contact. That contact occurred during episodes to manage aggressive behavior and/or facilitate the administration of medication by staff to patients under involuntary (court ordered) treatment in the locked patient care area. Both guards identified that they had received an initial training for their duties but were not aware of a plan to update work competencies annually. Staff Member #6 verified that s/he had worked at the facility for greater than one year. 2. On the same day at 11:20 AM in a subsequent discussion with the Infection Preventionist (Staff Member #1) s/he verified that one security guard did not have access to online training system designed to update competencies annually, and more specifically to a module titled, "Regulatory Readiness". This was observed on the "My Learning" annual training system.	L 590		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This WAC is not met as evidenced by: Based on observation, staff interview and review of policy and procedure, the facility failed to assure that patients, visitors and staff were provided with a clean environment. Item #1 - Upper Casework Cabinetry Findings:	L 780		

By signing, I understand these findings and agree to correct as noted:

PRINTED: 12/31/2015
FORM APPROVED

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L 780	Continued From Page 4 1. On 12/9/2015 at 8:30 AM Surveyor #1 observed that numerous (over 20) pieces of 8 x 11 inch reference papers were affixed to the upper cabinetry in the medication room. It was similarly noted that reference papers were affixed to the upper cabinetry located along the back wall of the nurses' stations. 2. On 12/9/2015 at 9:30 AM Surveyor #1 interviewed an environmental services staff member (Staff Member #2) about the process for cleaning upper casework cabinetry. S/he stated that s/he cleaned the cabinetry around the periphery of affixed reference papers which resulted in less than full cleaning of the surface. Additionally, s/he stated that s/he cleaned the cabinetry along the back wall of the nurses' station once a week and the cabinetry in the medication room once a day. 3. In review of facility policy 481 titled, "Environmental Services" in the section titled, "Offices, Waiting and Reception area, secretarial areas" item 1 stated, "Damp dust, using germicidal detergent solution, all. . . cupboards. " The policy did not state how often they should be cleaned. Another policy, "Env-2" titled, "Frequency Schedule for Specific Areas" did not identify the frequency for cleaning cabinetry accessed for patient care. However, another policy titled, "Cleaning and Decontamination of NON-PATIENT CARE" which applied to "work stations" stated that items should be cleaned and disinfected "when visibly soiled or at least daily". A work document titled, "Daily Duty List #: 100"	L 780		

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L 780	Continued From Page 5 referenced cleaning the "Nurses Station" and "Med Room" on a daily basis but did not provide more specificity. Item #2 - Common Space Furniture Findings: 1. On 12/9/2015 at 9:50 AM Surveyor #1 observed that patterned fabric of upholstered furniture in the common space appeared to be worn and soiled. The furniture was available for use by patients, visitors and staff on the locked unit. The seating capacity of the furniture was for 10 patients/others and the seating was observed to be regularly and intermittently occupied on the locked unit. Other options for use of upholstered furniture were limited in the secured unit (not available in patient room and other locations). 2. On 12/9/2015 at 10:00 AM Surveyor #1 interviewed an environmental services staff member (Staff Member #2) about the process for cleaning the patterned upholstered furniture located in the common area. S/he stated that s/he did vacuume the furniture but did not use a germicidal product on the fabric. 3. In review of policy 481 titled, "Environmental Services" under the section "Furniture and Furnishing" item #1 instructed staff to use a dry vacuum and item 2 stated "Spot clean upholstered furniture as necessary. Deep cleaning will be performed by professional cleaners." 4. On 12/10/2015 at 9:30 AM Surveyor #1 interviewed the Director of Environmental Services (Staff Member #3) about the furniture of reference. S/he stated that the furniture was last cleaned by professional cleaners in March-April 2015 (6-7 months prior). A routine cleaning	L 780		

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L 780	Continued From Page 6 schedule for professional cleaning of the upholstered furniture could not be identified.	L 780		
L 880	322-140.1i ROOM FURNISHINGS WAC 246-322-140 Patient living areas. The licensee shall: (1) Provide patient sleeping rooms with: (i) Sufficient room furnishings maintained in safe and clean condition including: (i) A bed for each patient at least thirty-six inches wide or appropriate to the special needs and size of the patient; (ii) A cleanable, firm mattress; and (iii) A cleanable or disposable pillow; This WAC is not met as evidenced by: Based on observation, and review of hospital's policies and procedures, the hospital failed to provide a safe and clean environment for its patients. Findings: 1. Hospital policy titled, "Clostridium difficle (C.diff) and Multidrug Resistant Organism Discharge and Daily Room Cleaning Protocol" (Procedure 7.12) (Date Issued 4/1/2014) on page 3 part 10 stated, "Wipe down the patient bed. . . (a) Inspect mattress prior to cleaning for rips, tears, leaks. Report any of these to your supervisor". On 12/10/2015 at 9:00 AM, Surveyor #2 observed mattresses torn in rooms I and D which were no longer cleanable. After reviewing policy and procedures for discharge cleaning and daily cleaning, (policy numbers 481-5 and 481-4) there	L 880		

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L 880	Continued From Page 7 was no mention of what to do with torn mattresses.	L 880		
L 945	322-140.8 TELEPHONE ACCESS WAC 246-322-140 Patient living areas. The licensee shall: (8) Provide a readily available telephone for patients to make and receive confidential calls; This WAC is not met as evidenced by: Based on observation and interview, the facility failed to provide a readily available telephone for patients to make and receive confidential calls. Findings: 1. On 12/9/2015 between 8:30 to 11:30 AM Surveyor #1 observed several patients use a phone located on the counter of the nurses station to place and conduct personal phone calls. The area was located centrally in open space and readily available for public viewing and listening. 2. On 12/9/2015 at 11:35 AM Surveyor #1 interviewed the Director of Nursing (Staff Member #4) about the set-up for patients to make and receive confidential calls. S/he stated that a second phone for patient use had been previously available at another location on the unit. But that phone had been removed and not replaced.	L 945		
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement	L1375		

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L1375	Continued From Page 8 procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c) Administering drugs; This WAC is not met as evidenced by: Based on observation, interview and review of policy and procedure, the facility failed to assure that standards for patient identification for medication administration were adhered to. Findings: 1. In review of facility policy titled, "Medication Administration" on page 3 of 22 item E. was titled, "Armband and Patient Identification Process". It included a section specific to the psychiatric hospital ("LCC") and it stated, "A binder with each patient's photo and armband will be kept in the medication room for patient identification. This will be utilized only when a patient cannot be scanned due to instability, refusal and or if the armband is not operational. The staff may utilize the armband copy for scanning in addition to the standard two (2) identifier methods outlined above [first and last name and date of birth]. The patient identification process includes having the patient state his/her name, date of birth and checking or scanning the armband." 2. On 12/9/2015 beginning at 8:05 AM, Surveyor #2 observed successive medication administration to Patients #1-4 by a nurse (Staff Member #5). Patients #1, #3 and #4 were administered medications subsequent to identification by scanning their individual armbands (not asked to state their first and last names and date of birth or identified by use of the "Patient Information and Armband Book"). Patient #3 did not have an armband on and was asked by the nurse to state	L1375		

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L1375	Continued From Page 9 her/his date of birth which was confirmed with content of the "Patient Information and Armband Book". However, the patient information book did not contain the patient's photo. The armband located in the book was used for scanning and then the medication was administered. 3. Immediately subsequent to the above observation, Surveyor #1 asked the nurse (Staff Member #5) about the use of the "Patient Information and Armband Book". S/he stated that s/he rarely used the book and was aware that Patient #3's photo was not present in the book at the time of use.	L1375		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This WAC is not met as evidenced by: Based on observation, the hospital staff failed to implement policies and procedures consistent with the Washington State Retail Food Code, WAC 246-215. Findings: On 12/10/2015 at 11:00 AM Surveyor #2 observed mouse droppings in the storage area outside of the facility where single service articles (paper plates, bowls, cups) were stored in open containers exposing them to the outside enviroment. The facility discarded open containers and the contents. Reference: 246-215-06550 Methods-Controlling	L1485		

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L1485	Continued From Page 10 pests (2009 FDA Food Code 6-501.111).	L1485		

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